State of Illinois
Department of Children and Family Services

ADOPTION ASSISTANCE APPLICATION

(SECTION I TO BE COMPLETED BY THE WORKER)

If you do not wish to apply for adoption assistance, complete Sections I, II and III.

If you wish to apply for adoption assistance complete Sections I, II and IV.

I. ADOPTIVE PARENT AND CHILD INFORMATION

Adoptive Parent _____ Home Telephone Number _____

Adoptive Parent _____

Address _____ City _____ State _____ Zip Code _____

Child's Name _____ Date of Birth _____ / _____ / _____

II. INFORMATION REGARDING ADOPTION ASSISTANCE

Following is information regarding the availability of adoption assistance for the child you are planning to adopt. Please indicate the types of adoption assistance for which you wish to apply.

1. Nonrecurring Expenses for Adoption Assistance

   One-time only payment for expenses incurred during and related to the adoption process. Eligible expenses include but are not limited to reasonable and necessary adoption fees, court costs, attorney fees, guardian *ad litem* fees, travel expenses related to pre-placement visits, health and psychological examinations and other costs associated with the legal adoption of a special needs child subject to the maximum set by the Department of $1,500 per adopted child.

   A) Families who wish to apply for reimbursement for nonrecurring adoption expenses shall submit the CFS 1800–B–A, Application to the appropriate Adoption Coordinator/Supervisor.

   B) Approval shall not be given for any part of nonrecurring adoption expenses that are paid or reimbursed through another state or federal program.

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

C) Following DCFS approval to pay or reimburse non-recurring expenses, the worker shall send the CFS 1800–C–A to the family for signature.

D) Adoptive parents sign the CFS 1800–D Direct Payment to the Attorney to authorize direct payment to the attorney handling the adoption if the attorney is a member of the Statewide Adoption Attorney Panel. If the attorney is not a member of the Statewide Adoption Attorney Panel, the adoptive parent(s) is responsible for paying the legal fees. The adoptive parent(s) may be reimbursed for legal fees upon submitting an invoice indicating that fees were paid in full and a copy of the Judgment Order for Adoption.

☐ I request this assistance. ☐ I **do not** request this assistance.

2. Monthly Cash Payment

The amount of the monthly cash payment is determined in accordance with DCFS Rules and Procedures 302.310 and shall not exceed the amount the child receives in their current foster family home unless the child is in an unlicensed relative placement. In such a case, upon adoption finalization, the adoptive family may receive up to the applicable DCFS rate for licensed foster family homes.

☐ I request this assistance. ☐ I **do not** request this assistance.

3. A Medicaid Card

A Medicaid card will be issued for the child upon completion of the adoption. This card shall be used for all Medicaid-eligible services obtained through Medicaid-enrolled provider(s) that are not payable through your health insurance or through other public resources. If there is not a Medicaid enrolled provider within 25 miles of the child's home, services may be obtained from a provider who does not participate in the Illinois Medicaid Program. If the adoptive parent(s), who now reside in Illinois, move to another state in the future, the change in residency may affect their ability to receive a Medicaid card in that state for their child as Medicaid eligibility requirements vary from state to state. When a family moves out of state or currently resides out of state and that state will not provide Medicaid coverage, Illinois will reimburse the adoptive family at the Illinois Medicaid rate for eligible services. If an out-of-state medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program.

☐ I request this assistance. ☐ I **do not** request this assistance.

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

4. Payment for Other Approved Services

a) Needs Not Payable Through Other Sources

This payment is for allowable medical, emotional and mental health needs not payable through insurance or public resources that are associated with a pre-existing condition documented on the CFS 1800–B–A Application for Adoption Assistance prior to the finalization of the adoption. Payment cannot be made until the Department has been notified in writing that such services will begin, has approved the requested services and a contract (when applicable) with the identified vendor is in place. The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

Current Services Not Payable through other sources:

The child is currently receiving the following services that will be continued upon the finalization of the adoption. Include only those services which are not paid for through other sources and that are allowable per Rule 302.310 Adoption Assistance (Add additional pages if necessary);

Service	Current Provider

☐ I request this assistance. ☐ I **do not** request this assistance.

b) Therapeutic Day Care

Therapeutic day care provides services to children who cannot be served in traditional childcare services or other childhood programs because of their inability to participate in such programs and because of the intensity of the services they require as a result of their physical, mental or emotional disabilities.

Payment will be made for therapeutic day care only for those children who are determined to have a disability, which requires special educational services through a current, Individual Education Plan (IEP), an Individual Family Services Plan (IFSP), or a 504 Educational Special Needs Plan updated on at least an annual basis, when such day care is not payable through another source. In order for payment to be made, the worker must obtain a copy of the current IEP or IFSP or 504 Educational Special Needs Plan.

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

i. Payment may be made for therapeutic day care that provides therapeutic intervention rather than only regular childcare services. The day care must include treatment of a disability or a disease as an integral part of the programming (i.e., speech, physical or occupational therapy, behavior modification, psychological or psychiatric services).

ii. Approval of payment for therapeutic day care requires documentation of the child's specific medical, mental or emotional disability as stated in the IEP, IFSP or 504 plan and the special training, licensing or credentialing of the individual providing the therapeutic day care.

iii. Payment for therapeutic day care cannot be made until the Department has been notified that such services will begin, has approved the requested services, and a contract with the identified vendor is in place (when applicable).

iv. The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

☐ I request this assistance. ☐ I **do not** request this assistance.

c) Employment Related Day Care for Children Under Age 3

Adoptive parent(s) receiving assistance for a child under three years of age are eligible for payment of day care services for that child, if day care is required due to one of the following. (Check the appropriate box below).

i. ☐ The parent(s) employment or participation in a training program will lead to employment.

ii. ☐ A single adoptive parent is employed or both parents in a two parent adoptive home are either working or in a training program.

iii. ☐ One parent works and the other parent is unable to care for the child due to a disability.

☐ I request this assistance. ☐ I **do not** request this assistance.

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

III. REFUSAL OF ASSISTANCE

The adoption assistance program has been explained to me/us, and I/we understand that benefits are available to the eligible child. However, I/we do not want to apply for any component of adoption assistance benefits or services as detailed in Section II of this document.

I/We understand that as a result of this refusal, we will not be able to apply for or receive any of the benefits or services available under the Adoption Assistance program after the finalization of the adoption.

_____ _____
Adoptive Parent Date

_____ _____
Adoptive Parent Date

IV. ACKNOWLEDGEMENT

I/We, the undersigned, hereby apply for adoption assistance from the Illinois Department of Children and Family Services (DCFS).

1. I/We understand that health-related adoption assistance payments cannot be made if my/our health insurance coverage or community resources, including DPA Medicaid, can appropriately meet the child's health-related needs

2. I/We understand that the Department cannot pay for health insurance deductibles or make co-payments for medical services, nor supplement health related payments made by health insurance or DPA Medicaid.

   Information to be provided by adoptive parent(s)

   ☐ Check box if child will be insured by the family's health insurance provider.

   Name of Company _____ Policy number _____

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

3. I/We understand that after the child's adoption, I/we must apply for such financial benefits to which the child may be entitled (such as Supplementary Security Income or Veterans benefits).

   The child is presently eligible for:

Benefit	Amount	Verified by	Date
☐ Social Security Benefits	_____	_____	_____
☐ Veterans Benefits	_____	_____	_____
☐ Other (specify):			
_____	_____	_____	_____

   Any benefits the child currently receives may be affected by assistance through the Adoption Assistance program~~s~~.

4. I/we are unable to adopt the child without assistance.

5. I/We understand that the following information is necessary for the Department to meet the reporting requirements of the Adoption and Foster Care Analysis and Reporting System (AFCARS) mandated by Section 479 and 1123A of the Social Security Act.

Adoptive Parent # 1:

_____

Date of Birth ____ / ____ / _____

Check all that apply:

RACE:
- ☐ Black or African American
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Undetermined

Hispanic Origin (Y/N): ___

MARITAL STATUS:
- ☐ Married
- ☐ Civil Union
- ☐ Single Mother
- ☐ Single Father

Adoptive Parent # 2:

_____

Date of Birth ____ / ____ / _____

Check all that apply.

RACE:
- ☐ Black or African American
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Undetermined

Hispanic Origin (Y/N): ___

Child's Name: _____

Adoptive Parent(s) Name: _____

Date: _____

6. I/We understand that I/We may appeal the determination of DCFS regarding this application in accordance with 89 Ill. Adm. Code Part 337, Service Appeal Process.

   Adoptive parent(s) may appeal the Department's decisions regarding payment for adoption assistance in accordance with 89 Ill. Adm. Code, Part 337, Service Appeal Process.

   Decisions or actions made by the Department are appealed after the adoptive parent(s) has received notice of the decision or action. Any written notices from the Department will provide specific information about the appeal rights of adoptive parents, guardians and foster parents.

   To appeal a decision or action made by the Department, a written request for a service appeal is submitted to:

   Administrative Hearings Unit
   Department of Children and Family Services
   406 E. Monroe, Station 15
   Springfield, IL 62701
   217.782-6655

7. I/We have read and understand the application.

_____ _____ - _____ - _____
Adoptive Parent SS#

_____ _____ - _____ - _____
Adoptive Parent SS#

_____
Date